



Date: _____

Account # _____ - _____

Patient Name: _____

SVMC FINANCIAL DISCOUNT/CHARITY CARE APPLICATION

| | | | | |
|--|-------|--------|-------------------|------------|
| LAST NAME (PATIENT) | FIRST | MIDDLE | SOCIAL SECURITY # | BIRTH DATE |
| MOTHER'S MAIDEN NAME: | | | | |
| RESIDENCE ADDRESS (FACILITY ADDRESS IF HOMELESS) | | | HOW LONG | PHONE |
| CITY | | STATE | ZIP | |

| | | |
|---|-------------------------|-----------|
| LAST NAME (GUARANTOR IF DIFFERENCE FROM ABOVE) | SOCIAL SECURITY # | BIRTHRATE |
| EMPLOYER OF GUARANTOR (NAME AND FULL ADDRESS) | | |
| PHONE | MONTHLY GROSS PAY \$ | |
| OTHER EMPLOYER (NAME AND FULL ADDRESS) | | |
| PHONE | MONTHLY GROSS PAY \$ | |
| IF UNEMPLOYED, NAME OF LAST EMPLOYER AND FULL ADDRESS | | |
| LAST EMPLOYMENT DATE | | |

| DEPENDENT FAMILY MEMBERS (If more space is needed, please attach an additional sheet of paper) | BIRTH DATE | RELATIONSHIP | EMPLOYER & EMPLOYER PHONE | MONTHLY GROSS PAY |
|--|------------|--------------|------------------------------|----------------------|
| 1. | | | | |
| 2. | | | | |
| 3. | | | | |
| 4. | | | | |
| 5. | | | | |
| 6. | | | | |
| 7. | | | | |
| 8. | | | | |
| 9. | | | | |

| | | | | | | |
|---|--------------|--------------------|--|--|------------------------------|--------------------|
| RENT HOME OWN HOME | | | OTHER MONTHLY INCOME \$ SPECIFY SOURCE | | | |
| OWED TO OTHERS | TO WHOM OWED | PRESENT BALANCE | MONTHLY PAYMENT | ASSETS | BANK NUMBER & ACCOUNT NUMBER | ACCOUNT BALANCE |
| RENT/MORTGAGE | | | | CHECKING | | |
| UTILITIES | | | | SAVINGS OR CERTIFICATE | | |
| FOOD | | | | 403(B) OR 401(K) | | |
| AUTO LOAN | | | | STOCKS & BONDS | | |
| | | PRESENT BALANCE | MONTHLY PAYMENT | ASSETS | BANK NUMBER & ACCOUNT NUMBER | ACCOUNT BALANCE |
| CREDIT CARDS | | | | IRA | | |
| | | | | AUTO (YEAR & MAKE) | | |
| | | | | AUTO (YEAR & MAKE) | | |
| | | | | | | |
| OTHER OBLIGATIONS (CHILD SUPPORT, ALIMONY, INSURANCE PAYMENTS) | | | | RESIDENCE MARKET VALUE | | |
| ADDITIONAL INFORMATION | | | | INSURANCE CASH VALUE | | |
| BILLS OWED TO OTHER MEDICAL PROVIDERS | | | | OTHER ASSETS (DESCRIBE. E.G., SECOND HOME) | | |
| COST OF PRESCRIPTION MEDICATION(S) | | | | | | |
| TOTAL DEBTS | | | | TOTAL ASSETS | | |

I CERTIFY THAT ALL STATEMENTS MADE IN THIS APPLICATION ARE TRUE AND COMPLETE. YOU ARE
HEREBY AUTHORIZED TO CHECK MY CREDIT HISTORY IN ORDER TO EVALUATE THIS APPLICATION
FOR FINANCIAL ASSISTANCE CONSIDERATION.

| | |
|----------------------|----------------------|
| SIGNATURE | DATE |
| | |

In order for this application to be considered for Financial Discount/Charity Care, ALL of the following documents are required, if applicable

- **Completed Financial Discount/Charity Care Application Form**
- **A copy of the prior year tax return**
- **A copy of current pay stubs (2 most recent)**
- **A copy of social security, disability, or unemployment check or award letter**
- **A copy of a state AHCCS/Medi-Cal Decision/Denial Notice. You can obtain this by contacting the AHCCS/Medi-Cal office in the area in which you live. All potentially eligible patients must provide a valid "Notice of Action" from AHCCS/Medi-Cal stating completion of the application and the reason for acceptance or denial. Any Notice of Action stating a failure to provide information or failure to participate in the interview will not be accepted in consideration of this Application for Financial Discount/Charity Care.**
- **Hardship Letter (outline the reason you are requesting financial assistance).**
- **Last Two Bank Statements (detailed)**

Please return your completed application with all requested forms in the enclosed self-addressed stamped envelope within 15 days. Contact: **St. Vincent Medical Center** at **213 484 7163** if you have any questions.

Please be advised that this is not a guarantee that financial assistance will be awarded; and payments should continue on a regular basis until a determination has been made. Your application and the information provided will be reviewed and verified and a decision will be provided to you in writing.

Thank you for your cooperation. We look forward to being of assistance to you to resolve your account.

Return by this Date: _____

Account Number: _____ Account Balance: \$ _____